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# HELPING A BILLION CHILDREN LEARN ABOUT HEALTH

Report of the WHO/UNICEF International Consultation on
Health Education for School-age Children,
Geneva, 30 September to 4 October 1985

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## Preface

School-age children number nearly a billion around the world. More than half of them are attending school, but many millions, probably hundreds of millions, are not.

Whether or not they are receiving any kind of formal education, however, these children are learning about health every day. From their parents, their siblings and peers, their communities and many direct and indirect media of communication, they are developing values and attitudes and acquiring, or not acquiring, the knowledge and skills that will shape their health for their lifetime. Moreover, these attitudes and values will determine the world's health as these young people become the parents and leaders of the future.

Therefore, for everyone concerned with health for all, rooted in systems of social justice, empowering these children to manage their health destiny so as to enhance the quality of their lives is of paramount importance. It is fundamental to the achievement of a healthier world.

Successfully influencing the health learning of children, in school and out, in developing and developed countries, requires the commitment and effective deployment of many resources. But it also requires much more: an infusion of imagination and an intensity of effort by many people in many places.

A further requirement is willingness, on the part of the institutions of society which deal with children and their health and education, to examine their own value systems and consider changes which may appear undesirable and are often uncomfortable. Systems which extol self-reliance but in fact create increasing dependency have no credibility and deserve none, especially with children who have a clear-eyed view of reality.

Thus the challenge implicit in strengthening the health education of a billion school-age children goes beyond the refinement and widespread application of existing methodologies and the development of new ones, though these will surely help. It involves seeing children as a whole, in the context of their diverse social, cultural and physical environments. It involves looking at the ways they learn, the influences that shape their beliefs. Finally it requires a creative, multi-faceted set of inter-related programmes and activities at every level, from the global to the community.

The participants in this Consultation recognized the far-ranging scope of the subject and the limitations imposed by the time available. However, if this report is seen as a first step leading towards, and perhaps helping further steps to be taken on, the exciting road to be followed, it will have served a valuable purpose.

Finally, I wish to take this opportunity to express my appreciation to Dr Akbar Moarefi, WHO consultant in charge of organizing the WHO/UNICEF International Consultation on Health Education for School-age Children, for his significant collaboration, and to Mr Horace Ogden, WHO consultant responsible for preparing the present report, for his perceptive synthesis of the discussions.

Jack C.S. Ling
Director
Division of Public Information and
Education for Health

# 1. THE CONSULTATION

## 1.1 Sponsorship and participants

WHO and UNICEF jointly invited participants from 21 countries to an International Consultation on Health Education for School-age Children, held in Geneva from 30 September to 4 October 1985.

The group was intentionally highly diverse, both in origin and in expertise. Developing and developed countries were more or less equally represented as were the sectors of health and education. In addition there were participants experienced in communication, behavioural science and public administration. Also in attendance were representatives of several interested UN and nongovernmental organizations, together with headquarters and field staff of the sponsoring agencies.

## 1.2 Purpose

The work of the group focused on three general areas of concern:

(a) consideration of the scope and complexity of the problem of health learning on the part of school-age children, both in and out of school;

(b) describing and assessing the current state of health education activities for this school-age population, including the issues, constraints and evident gaps;

(c) proposing strategies and guidelines for strengthening health education in countries and communities by all possible means for the ultimate purpose of contributing as much as possible to the enhancement of the quality of life of children and youth.

## 1.3 Definitions

Definitions of terms in the title were kept deliberately flexible.

It was generally agreed that "school-age children" implied a primary, but by no means exclusive, concentration on children aged roughly 6-14 years, the age-group corresponding to mandatory school attendance in most countries.

"Health education" was interpreted very broadly, to include informal approaches through many channels, in addition to the formal school curricula and service programmes.

## 1.4 Procedures

The Consultation met in several plenary sessions at which a series of background papers was presented and discussed. A major part of two days was devoted to work in discussion groups. The reports and recommendations of the three working groups were consolidated into a single report and presented in draft form for consideration at the concluding plenary session.

The three discussion groups were formed, first by language -- two English speaking, one French -- and then by target. The French group and one English group were asked to consider strengthening health education for children attending school. The second English-speaking group addressed out-of-school children.

Consensus rather than formal adoption was sought; no votes were taken. Discussion was vigorous, as indeed it was throughout the week, and differences of opinion were freely expressed.

Sections 2 and 3 of this report discuss, respectively, the nature and dimensions of the problems addressed and some approaches and experiences shared by the participants, whereas section 4 reflects the strategies, guidelines and suggestions emerging from the Consultation as a whole, taking note also of issues not completely resolved.

## 2. NATURE AND SCOPE OF THE PROBLEM

In 1982, with the population of the world estimated at 4 586 million, some 870 million persons were enrolled in schools. Of these, 580 million were at the primary or elementary level representing roughly ages 6-14.

All these numbers are growing rapidly. And they do not take into account hundreds of millions of school-age children who are not in school. According to one estimate, there are at least 55 million children in the world who are employed in factories or similar settings. Thus it is a safe guess that we are dealing with a universe of more than a billion young people growing toward adulthood.

They are as diverse as the myriads of environments and cultures in which they live. But for purposes of this Consultation they have some important commonalities:

Firstly, these school-age children are members of a "privileged" group who have survived the perils of infancy and early childhood. Having done so - while many millions of their birth cohort did not - they tend to be a fairly healthy lot. In most societies, though not all, mortality rates for this age-group are lower than for those younger and older groups, though this does not mean that they are not subject to a wide range of debilitating diseases.

Secondly, they are learning. Even those who are, and will remain, untouched by formal education are acquiring and refining values and attitudes towards themselves and their world. They are acquiring and processing information from many sources on how to live, how to behave, what is important and why. Much of this information relates very closely to their health, although they may not use the word or even recognize the concept.

Thirdly, they are tomorrow's adults. The 21st century belongs to them, and to their children and grandchildren. They and their descendants are the "all" in Health For All by the Year 2000 and beyond.

One foundation on which the primary health care strategy is based is the recognition that health for all can only be achieved through effort by all. People need to be brought into full partnership in pursuit of a higher quality of life. Such a partnership must be built on confidence and competence — confidence that change is possible and desirable, and competence to manage one's own health affairs in a context of community responsibiity.

The health education that is needed by our billion school-age children is a dynamic process that will help empower and encourage them to play their part in the partnership.

### 2.1 Who are these children ?

It is convenient to divide the school-age population into two basic groups -- those who are enrolled in school, and those who are not. In fact, as has been noted, the Consultation chose this classification in dividing into work groups, and it will be used for descriptive purposes in this section. However, this division can be deceptive. For with the sole exception of the formal schooling itself, in-school and out-of-school children are subject to the same multiple influences that affect their attitudes and behaviour and, of course, derive their basic values from the same sources.

For obvious reasons, more is known about the children who attend school than about those who do not. We have a reasonable estimate of their number -- some 580 million at the elementary level alone. We know by their school attendance that they are conforming at least to some extent to their society's norms, and that those norms include placing a value on education and instruction. For those concerned with influencing their learning about health, this group offers the great advantage of being accessible through an operating institution — the country's educational system. They are to some extent a "captive audience". They are also oriented, to a greater or lesser extent, to organized patterns of learning. For this reason, by far the largest share of organized effort in health education for the school-age child has been directed toward and through the school systems. Indeed until very recent times, virtually all of it has been so addressed, except for a limited amount done through youth organizations and media.

Beneath these broad common elements, however, in-school children are very far from homogeneous. Many are "in-school" very briefly, for a variety of reasons ranging from

economic necessity to a sense of impatience with perceived irrelevance. At least insofar as health is concerned, it can probably be assumed that their learning is unaffected, or certainly not benefited, by the school experience, and that they have more in common with the out-of-school youngsters whom they quickly join than with the rest of the in-school group.

These drop-outs are, of course, a minority. Most of their peers remain, at least through the elementary years, and are exposed by virtue of school attendance to a number of factors which may affect their learning about health. These factors, which include not only the curriculum but also the school environment and the school health services provided, will be discussed in a subsequent section.

About the out-of-school population very little is known. Indeed there is an urgent need for the systematic collection and analysis of objective data on this group. We need to know who they are, where they are, through what channels they receive information and how they process it.

What we do know is that the out-of-school group varies widely in size from country to country, from community to community, and from one age-group to another even within communities. We know that substantial numbers exist in both urban and rural settings, and that although it is probably a more widespread problem in developing countries, it is by no means unknown in the most highly developed socieities.

From observation of various countries it can be inferred that school-age children not attending school fall into at least six general categories:

(i) Children who live at home and are engaged in some form of organized labour. (An example was cited of thousands of school-age children working in match factories.)

(ii) Children who remain at home and are engaged in some aspect of the home economy. (Examples include working in the fields, minding the flocks, or caring for younger siblings so that parents can work.)

(iii) Children for whom formal schooling is accorded no value by their subculture (e.g. females in some areas or ethnic and religious groups).

(iv) Children isolated from school by reason of geographic inaccessibility or physical handicap.

(v) The "street children" of large cities who have lost or severed contact with family and traditional social structures.

(vi) "Refugee children" who are part of societies disrupted by major catastrophes.

## 2.2 Factors influencing health behaviour

Factors influencing the health behaviour of children begin with the values, beliefs and attitudes of their social and cultural environment and the economic realities of their family and community. Health, in fact, cannot, in any realistic way, be separated from the total development of the person or the society. Its presence makes fuller development possible; its absence imposes heavy restrictions on what is attainable. But relatively few children in today's world absorb from their environment the concept that health is a high-priority asset, or that they themselves can be instrumental in affecting it.

Today's school-age children, whether in school or not, are the recipients of many more messages related to their health than any previous generation. The social forces that influence attitudes and behaviour in relation to health have multiplied and diversified remarkably in the past 20 years, in developing and developed countries alike. Among these changes are:

(i) Increased mobility of the population, predominantly from rural to urban areas but also urban-to-urban and indeed country-to-country.

(ii) Increased coverage of schools, whose presence affects the entire community and not just the children in attendance.

(iii) Increased levels of child and adult literacy.

(iv) Proliferation and strengthening of concerned groups such as women's organizations, youth-serving agencies, voluntary associations, etc.

(v) Greatly increased penetration of the mass media of communication which, for both good and ill, literally opens eyes and ears to the almost infinite diversity of the human condition.

All of these forces are generators and accelerators of change. Their presence offers an enormous arsenal of resources by which learning about health can be enhanced. To begin to realize their potential, health and education professionals will need not only to work together but also to reach out and involve many other sectors and disciplines.

Mass media offer a special case in point. Access to radio-broadcasting is becoming almost universal. The rapid improvement of literacy levels is greatly extending the outreach capability of the newspaper and other print media. In many countries and communities, television has become a part of the daily lives of rich and poor alike.

The impact of these media on values, attitudes and behaviour is above question. For school-age children, who have been born into an age of communication explosion, the impact may be most pervasive of all. Yet many health professionals have tended to lament the negative effects without making a significant effort to turn the power of the media to public advantage. Shedding this professional reluctance to engage the media in a common cause offers great promise for health learning.

## 2.3 Health learning and the health sector

To the extent that school-age children come into contact with health workers, these encounters should have a substantial impact on the health-related values and attitudes they are developing. In fact they probably do, but whether or not the impact is generally desirable is open to question, depending on the values and attitudes we seek to promote.

Traditionally people come, or bring their children, to see a doctor or other recognized health worker in time of sickness. They come as supplicants seeking a cure, with an attitude of dependency if not of desperation. Too often, what is done and the manner in which it is done, reinforce that dependency. When this happens, the child's attitude toward himself and his own health has been damaged, regardless of the medical outcome. When, in contrast, the physician or health worker takes advantage of the encounter as an educational opportunity, much can be accomplished to inculcate different values.

Public health education programmes of the health sector, outside the medical care setting, have tended to be strongly disease-oriented. Frequently they have taken the form of educational campaigns in support of a single categorical purpose -- polio and venereal disease control are typical. These separate campaigns have often been helpful in coping with the immediate problem, but there has been little cumulative effect on health learning.

Today, especially in the developed countries, there is a trend toward broader-gauged action-oriented health education programmes emphasizing prevention, risk reduction and health promotion, embodying a more positive and integral view of health, including its mental and social as well as physical aspects. The concept of individual and collective responsibility for individual and collective well-being is central to this approach.

As this approach, which is directly compatible with the primary health care concept, gains wider acceptance, school-age children should begin to acquire the attitudes, as well as the knowledge and skills, to assume appropriate responsibility for their own health.

## 2.4 Health learning and the education sector

Children in school are influenced in their thinking about health by many factors, three of which are -- content of the curriculum, the school health services provided and the health-related aspects of the school environment.

Of all the factors influencing the health learning of school-age children, by far the most attention has been given, by professionals in health and education alike, to the content

and methodologies of school health curricula and the preparation of teachers to present this material. This strong emphasis is understandable, since, as noted before, the world's school systems offer the most newly universal "catchment basin" for young people. Whether or not the school health curriculum is the most pervasive influence, it clearly provides the most direct opportunity for intervention.

The nature and extent of formal health teaching varies from nothing at all, in many systems, to a carefully developed sequential curriculum extending through many or all grade levels in a few. In some schools, health teaching is characterized by "bits and pieces tacked on to other subjects", as one participant in the Consultation put it. In others it is fragmented -- a unit on family life education, another on dental health, a third on personal hygiene, scattered at various grade levels. Some systems teach health as a separate subject. Others integrate it on a planned basis into reading programmes, social and biological sciences, and so on.

Underlying this diversity are a number of legitimate and complex issues, many of which are dealt with in the strategies, guidelines and recommendations discussed later in this Report. Among them:

(i) What is the most effective way to integrate health education in the total school curriculum ?

(ii) How can the long-sought and rarely-found effective coordination of effort between the health and education sectors be achieved at national, regional and local levels ?

(iii) To what extent can already overburdened teachers and schools be reasonably expected to shoulder additional responsibilities for health learning ?

(iv) How can teachers lacking expertise and training in health be prepared to deal with the subject competently and confidently ?

(v) How can more effective links be established among schools, families and other community institutions, including the mass media, to minimize conflicts in value systems and maximise positive health learning ?

Health services provided to children in the school setting vary widely in kind and extent. In some countries and communities the school serves as a focal point for preventive services. In others the school offers only the most rudimentary care related to minor illness and injury, or virtually nothing at all. Responsibility for the administration of these services rests sometimes with the health and sometimes with the education authorities. In either case the manner in which the services are provided is certain to affect the child's view of himself and his responsibility for his own wellbeing.

The school environment, in which the child spends a significant part of his/her life, can serve as an exemplar. Water supply and sanitation facilities, the kind of food offered, the attention given to personal hygiene and safety and many other environmental factors are influential -- either positively or negatively -- in shaping the child's attitudes and behaviour.

## 2.5 Health learning and social change

Health education of school-age children takes place in a context of social change and can have a significant effect on the mental health and development of children. Profound social change, such as the loss of extended family and village culture through migration, can be very traumatic. Schools, by providing a well-ordered area of life, can help to counterbalance these effects.

By the same token, school health education which conflicts too sharply with practices and attitudes found at home can cause serious problems for the child. Constructive change can take place only in a climate of respect for the traditional values.

It is often observed that children can be effective "educators" of their parents. This indeed is true, but it is important that this "education" be done in a way that does not cause loss of face. An example cited was that "children cannot be taught to wear shoes if their parents cannot buy them".

In relation to social change and mental emotional development, consideration must be given to:

(i) heightening the sensitivity of teachers and health care professionals;
(ii) encouraging parent-teacher dialogue before the curriculum is established;
(iii) strengthening mediating structures such as parent-teacher organizations;
(iv) recognizing the problems implicit in "too much change too fast".

## 3. SELECTED APPROACHES IN HEALTH EDUCATION

At plenary sessions throughout the Consultation, participants heard and discussed a series of presentations on various approaches to health education of the school-age child. Some of these papers described in depth specific programmes now under way as examples of what appear to be current "success stories". Others addressed principles and experiences in a particular area of interest (e.g. family life education) or a particular communication channel (e.g. mass media). Finally there was a presentation of a global initiative now under way through UNICEF, with specific illustrations of activities in selected countries.

This chapter attempts to extract a few highlights from each of these presentations and, equally important, from the questions and comments that ensued in plenary discussion.

Valuable supporting information, anecdotal material and expressions of opinion are necessarily omitted.

### 3.1 Educational aspects of school health services

The School Health Services programme of the Department of Haute Savoie, France, was presented as an example of an educational approach to health service delivery in schools. The programme is based on the philosophy that to play an effective part in health education, school health services should take an interest in all aspects of the life of school-children, covering individual health, family environment, school environment and school-related factors. Such a knowledge of the children and their way of life makes possible both an individual and a collective educational approach, not only as regards the children themselves but also their parents, the school, administrative and service personnel, and all technicians whose activities have some impact on the children's environment.

The structures and mode of operation of the French School Health Services enable them to play a very special role in this field. The services consist of teams which include physicians, nurses, social workers and school psychologists whose specific and coordinated action makes it possible to cope with a whole range of problems encountered by the school-age child, including the educational aspect.

Services provided are of four general types:

(i) Medical examination for all children at school entry (6 years) and for as many as possible at age 13-14, plus follow-up examinations and services for pupils in need of special help.

(ii) Health education on a wide range of topics, including some selected by pupils themselves, presented by nurses at primary school level and in some cases by medical officers at secondary level, with assistance from teachers.

(iii) Indirect activities on behalf of children, including concern with the school environment, school feeding programmes and the conduct of adult education, including teachers and parents.

(iv) Active liaison with health-related services and other community groups to assure that child health needs discovered in the school progrmme are adequately met.

Vigorous and extended discussion of the presentation of the French Haute Savoie programme brought into focus several major issues of the Consultation. Among these were similarities and contrasts between developing and developed countries; the issue of whether teachers or health service personnel are the most appropriate presenters of health education in schools; and the training and motivation of teachers for health instruction.

Some participants felt strongly that the Haute Savoie model, though excellent, was not highly relevant to the developing world. One reason cited was the comparative scarcity of health personnel: "A village with one health worker may have five or ten teachers". Another related to priority: developing countries, especially those with many out-of-school programmes, could not, and probably should not, devote many resources to such a programme. On the other hand, it was pointed out that countries in all stages of development could learn from the Haute Savoie model in terms of the evident close collaboration achieved between health and education sectors.

On the question of "who should do school health education ?", consensus of the discussion was that in most circumstances teachers were more likely candidates than physicians and nurses. In addition to the very short supply of health personnel in most locations, it was observed that doctors in general are not likely to see this function as an important part of their role and are neither motivated nor prepared to communicate effectively with young people.

At the same time it was acknoledged that, while education may not be a high priority for many health workers, health tends to be given low priority by educators. Several participants indicated that in their countries "schools are a fortress", very difficult to penetrate with anything but the traditional curriculum of reading, writing and arithmetic. A wide variation in teachers' motivation for dealing with health was recognized, and the basic question was posed as to how teachers could be helped to gain confidence and competence in this subject area. There was general agreement that all teachers should receive some health training as part of their professional preparation. The importance of on-the-job training for teachers now in service was stressed. One procedure proposed was to identify well-established teachers already interested in health and make it possible for them to develop health awareness and skills among their colleagues.

### 3.2 Communication between children and health care providers

A very different model, but one which also involves direct participation in education of school-age children by health care providers, is represented by Project Health PACT, developed by the Schools of Nursing, Medicine and Dentistry at the University of Colorado, USA.

Project Health PACT is based on the premise that consumers need to approach health care as a problem-solving endeavour that requires active coping efforts, rather than as a situation calling for passivity and submission. Although active problem-solving is more effective than passivity and unquestioning compliance, most health care consumers unfortunately play a passive role when seeking professional health services.

The project teaches children from pre-school through high school how to interact with health care providers during health care visits. The children learn to resolve health problems and develop appropriate plans of care by collaborating with the health care provider. Project Health PACT teaches children to communicate effectively with health care providers through the use of five basic communication skills:

(i) TALK with the health care provider.
(ii) LISTEN and learn.
(iii) ASK questions.
(iv) DECIDE what to do, with help from the provider.
(v) DO - follow through.

Project Health PACT may be taught as a supplement to an established health education curriculum, or it may be taught separately from other health education classes. The hours of instruction vary depending on the students' grade level. For example, pre-schoolers are introduced to the participatory and assertive health consumer role in four half-hour sessions; seventh and eighth graders learn it in seven one-hour sessions. It may be taught to children in a wide range of locations, including their school classrooms, clinics, youth organizations, and at home. It may be implemented by school nurses, general health educators, dentists, teachers, physicians, clinic and hospital staff, parents, nurses and physicians' assistants.

Age-appropriate teaching materials, developed in consultation with the children themselves, are available to support the programme. The programme has been translated into Spanish and has also been adapted for use in Puerto Rico, where 150 fifth and sixth graders successfully piloted the programme in the autumn of 1984.

In addition, the "Project Health PACT Curriculum for Adolescents and Young Adults" is an 80-hour, one-semester consumer health education course which teaches adolescents to be responsible consumers in the health market place. They learn self-help skills to monitor their own health status. There is also an opportunity to become involved in a youth participation project: teaching younger children about health in a supervised setting.

In discussion it was recognized that the ultimate aims of Project Health PACT -- to prepare providers and consumers of health services for new roles and co-equal relationships, and to encourage personal responsibility for health -- are highly compatible with the primary health care strategy. Adoption of this particular approach in its entirety requires special circumstances which are rare even in the developed countries. However, the basic innovative ideas, especially those involving the active engagement of school-age children in their own health affairs, point to exciting possibilities for adaptation.

### 3.3 School health education: a country experience

The Malaysian experience in school health education and related issues and problems was presented and discussed. The presentation was based on the expressed philosophy that health education of the school-age child is an integral part of community health education and should be aimed at fostering activities that encourage children of school age to want to be healthy, know how to stay healthy, do what they can individually and collectively to promote and maintain health, and to seek help when needed.

School health education was viewed as one part of a broad-spectrum for formal, non-formal and informal education through which children learn about health. Among the points stressed were:

(i) The health approaches must recognise the people's expectations to be involved in the affairs of the school, the community and the world at large, and hence, must be geared to enabling children gain relevant knowledge, attitudes and behaviour, based on real-life experiences.

(ii) Health education of the school-age child needs to be guided by new policies, reflect appropriate technologies, develop human and other resources, strengthen multi-sectoral efforts and institute measures for continuous monitoring and evaluation.

(iii) Linkages between formal, non-formal and informal educational efforts is vital in realising effective health education of the school-age child and his/her preparation for a productive life.

In Malaysia the Ministry of Education assumes responsibility for health instruction and the Ministry of Health for school health services. The two sectors are jointly concerned with healthful living, a healthful school environment, and school-community relations. Comprehensive health appraisal is done on primary school entrance (age 6), primary school departure (age 11), and secondary school departure (age 14).

In the health instruction programme, until recently, health education was taught as a separate subject in the primary and lower secondary schools. Since 1982, however, a new curriculum has been introduced which emphasizes the 3Rs and proposes an integrated approach to subject-matter areas including health. In this framework, health education will be implemented incidentally in the first three years of primary school and formally integrated with other subjects in the second half of the primary school course. It is too early to determine the effects of this change and the extent to which health education will be integrated throughout the school experience.

Discussion of this trend toward integrated curricula was vigorous throughout the Consultation. Some participants felt strongly that health must be considered a special subject with specific provision of time and content in the curriculum. Others felt, however, that if health is treated separately, other teachers tend to consider it "someone else's affair" and not include it appropriately in relation to other subjects.

### 3.4 Family life education for school-age children

The presentation, based on experiences in Sri Lanka, pointed out that Family Life Education (FLE), a widely used term that evolved as a duphemism for sex education, has always

engendered mixed feelings among parents, teachers and policy makers. This duality among adults is often reflected in differences between private attitudes and public expressions. Young people themselves, however, are very clear about their need for FLE, and they also clearly perceive the adult uncertainties.

The need for some form of FLE is probably universal, but specific objectives, content and methods of imparting it are locality-specific. One widely considered issue is the age or class level at which it should be introduced. In Sri Lanka the 8th Grade, with children of about 14 years, is recognized as a critical period in adolescent development and therefore appears to be a good target for FLE to help with personal adjustments. Unfortunately, this conflicts with the country's school attendance situation, since the drop-out rate by Grade 8 has reached 41.8 per cent. This would suggest the need for earlier introduction in the curriculum and careful attention to programmes of out-of-school learning.

A survey was conducted of 343 boys and girls in Grades 7, 8 and 9, to assess their knowledge, beliefs and anxieties related to reproductive health. The survey revealed that although general biological knowledge increses during this three-year period, knowledge of sexuality remains static at a very low level of information, and many misconceptions and inaccuracies persist.

Along with the phenomena outlined above, another interesting behavioural characteristic was observed in this sample. They were questioned as to whom they would go, on encountering a problem (whatever its nature). Among the seventh graders, a vast majority went to their parents, but the percentage fell significantly at Grade 8, and kept at the same level at Grade 9. This change of behaviour therefore coincided with the onset of the "problem age" at school referred to earlier. On the other hand, the proportion going to a teacher at Grade 7 was less than half the total sample. It remained the same at Grade 8, but fell to almost half that value at Grade 9. Loss of such confidence as may have been felt earlier seems to have developed intensely in Grade 8.

By Grade 9, 80 per cent were turning to their peers. The message for adults, parents and teachers alike, is clear. Part of this may reflect a normal adolescent difference in reference systems, but it is evident that many of us are reluctant or unskilled, or both, in communicating with young people about important life problems.

The importance, as well as effectiveness, of mass media in reaching young people is well known. Paradoxically, these avenues are ill-exploited, or when exploited, are done with sensationalist objectives. On the contrary, media should offer not only a means of reaching out to the young, but also a channel for coming to know their fears, anxieties and needs.

In response to a series of media programmes conducted in Sri Lanka a few years ago, a large number of young people addressed the communicator, making enquiries about various difficulties they had. It was found that their anxieties mainly centred round guilt feelings and misconceptions, uncertainties and fears regarding the process of sexual development.

Constraints to launching effective FLE include the reluctance of professionals in both education and health, general adult ambivalence, fears of adverse political consequences, and a general resistance to change. The field is in need of redefinition.

In discussion, it was stressed that child development and family relationships should be the keystones of Family Life Education and indeed of health education itself. There is a tendency for FLE to place too much emphasis on sexuality and not enough on the whole human being.

A participant from a developing country stressed the problem of conflicting worlds confronting young people -- that of school, and that of the traditional home. Traditional families, for example, may want early marriage and child-bearing, whereas schools advocate the opposite. This school-society problem was acknowledged to be very widespread. Educational programmes targetted to adults as well as children may be one approach to its solution.

3.5 CHILD-to-child health education

The ideas embodied in the CHILD-to-child Programme, initiated in the UK in 1978, have been used in at least 70 countries in the developed and developing worlds. The concept is based on the observation that young children in most developing countries spend a great deal of their time caring for their younger siblings. By teaching them sound health principles, they can be helped to perform this task better. They will carry new ideas into the home and by so doing may greatly benefit children in the infant and pre-school years where the toll of mortality and morbidity is the most severe.

Development of this programme was achieved through collaboration between child health workers and educators from developed and developing countries. Multi-disciplinary teams met over a period of several weeks to share ideas in free discussion, prepare teaching material, and suggest ways of encouraging its use.

The selection of topics to be taught was based on two broad considerations: their importance in the hierarchy of health problems in the community, and particularly their relevance to the health of young children, and the extent to which there was a realistic role available for a primary school-age child to play in relation to the problem. Ideas initially recommended were grouped under five headings:

(a) eating well;
(b) children as health workers;
(c) providing a healthy and safe environment;
(d) children growing up;
(e) stimulating younger children.

Under each of these headings a number of separate projects were identified and developed into teaching material in a form now called Activity Status Sheets (AS). These were intended for use by primary school teachers, either unchanged or after local adaptation, but they can also be used by youth leaders, health workers, members of women's groups, etc. The sheets provide the essential factual information on the subject. They also suggest relevant activities in which to involve children in school, at home or in the community. For example, in measuring malnutrition children can be shown in class how to make a simple measuring device, and then after measuring each other under supervision, be encouraged to measure siblings at home. Other suggested activities include drama, role playing, composing songs, and the more ambitious conducting of specific surveys.

There can be no doubt that active collaboration at local level between health and education workers enhances the effectiveness of the Programme. Mothers (and grandmothers) may be resistant to new ideas on health practices brought home from school by an eight year-old child; their resistance is more likely to be overcome if they hear the same ideas in a mothers' group from a community health worker. Moreover health activities organized for children outside school are much more likely to relate to current problems, and to make a real contribution to the health of the community, if planned jointly by teacher and health worker.

This last point has been clearly recognized by doctors and other health workers across the world, so that many good CHILD-to-child projects have in fact been initiated by health workers rather than teachers. In fact, a survey has shown that health workers use the system more often than teachers. This may relate to the health workers acute concern for behaviour change.

It is important to note that the CHILD-to-child programme offers great promise for reaching the school-age children who do not attend school, since it can, and has been, adopted by many types of worker and organization.

In discussion, the question was raised: "When you arm children with health information through education, how do you guarantee that they will not claim too much authority ?" The answer to this problem lies in the way in which the information is given. Teachers need to perceive their role as helping children to help each other and their community.

3.6 Mass media

A presentation on the role, actual and potential, of mass media in influencing health learning for school-age children generated long and animated discussion. Among the major points presented were:

(i) The influences of mass media on values, attitudes and behaviour to support and reinforce the status quo benefits those who control it within a given culture. The media is also a powerful force for innovation in other cultures. This force may have very negative impacts as is the case with what is sometimes called the "parallel curriculum of crime, violence and behaviour detrimental to health". But this force can also be turned to very positive ends, in support of social justice and specifically the strategy of primary health care. It can help develop in people the capacity to "engineer their own lives" including their health.

(ii) Media are often incorrectly perceived by those in other sectors as being solely or primarily concerned with news. In fact, they are multi-dimensional, with the transmission of information as only one function. At least in the case of the electronic media, entertainment is the dominant function and entertainment programmes are the most influential in shaping values and behaviour, especially in young people. A great disadvantage of media is the lack of two-way communication in attitude formation.

(iii) Media have the greatest potential of all for reaching the non-school-going child, especially those in urban areas. What is needed is an integrated communication strategy among health professionals, educators and communicators to achieve common goals. This in turn will require policy decisions at the highest levels.

(iv) Advertising in media is another dimension which must be considered in relation to health education. Controversy goes from the very basic definition of what communication is, what it means to society, to the right and responsibility of imparting information, arousing emotions, setting patterns of behaviour detrimental to individual and community health and wellbeing, and other observable types of impact.

(v) There is an urgent need for research to further define the extent and nature of media impact on the values and behaviour of school-age children in various cultures, and the means by which this impact is attained.

In the ensuing discussion, there was general agreement that health professionals and educators need to involve mass media communicators in full partnership in the general effort to enhance health learning of school-age children. One or two participants from developing countries expressed the opinion that the investment of time and effort would be more beneficial if it were directed toward local folk media -- festivals, fairs, sports, drama and dance, etc -- which tend to reinforce traditional cultures. Most participants clearly felt that both mass and folk media were important and currently under-utilized for health.

It was pointed out that in some countries an ethical issue has been raised which has the effect of preventing physicians from taking part in education via the media. The group agreed that this was a false issue which should be laid to rest. Stress was also placed on the need to train physicians for communication, especially two-way communication.

Since the allocation of public airwaves is, to some extent, a governmental prerogative in almost all countries, the urgent need was expressed to make political leaders and decision makers aware of the impact of media on children so that decisions can be made that are truly in the public interest.

It was recognized that media messages are most effective in health education when they are reinforced by local person-to-person contact and written material. An experience was described in which some 1 500 "listening groups" were set up to view and discuss two one-hour television programmes on health topics which were broadcast nationally. As a by-product of this initiative, 1 200 of the groups have remained active to discuss local health affairs.

### 3.7 Child Survival and Development Revolution: a global strategy

The Child Survival and Development Revolution (CSDR) developed by UNICEF is directed toward rapid reduction of mortality and morbidity in infants and young children. The four specific actions given highest priority, all based on recent advances in technology and made possible by changes in social organization, are immunization, oral rehydration therapy, breast-feeding and growth monitoring. Worldwide acceptance of the primary health care strategy is among the social changes essential to CSDR's success.

The CSDR strategy offers an opportunity to energize health education for young people both in and out of school. It provides school-age children with specific action-oriented knowledge and skills which they can apply for the benefit of themselves and their families. The relevance recognizes the premise of the CHILD-to-child approach that children spend a great deal of time caring for younger siblings, and also the fact that today's school-age children are tomorrow's parents.

For the in-school population the main strategy elements are:

(a) re-orientation of teachers, educational management personnel and parents;
(b) production of resource materials for teachers and student activities;
(c) review and modification of curriculum materials, identification of needed changes in the teaching-learning process, and reform in the student evaluation and examination process;
(d) involvement of children in activities within their families and communities;
(e) use of the school as a physical base for certain CSDR activities in the community.

Strategies for out-of-school children are more difficult to define, but they include taking advantage of existing non-formal training programmes of various kinds, use of mass media, and working through religious, social and other groups which reach these children.

A UNICEF staff person in one developing country reported that in her country teachers were being oriented to become health workers in such areas as first aid and detection of eye problems and that the local school was coming to be viewed as a first-level focal point for the health of children and a gateway for CSDR. This was considered especially important because schools are much more widely available than local health centres.

A second field staff member reported on the use of village newspapers for reaching the community with health information. One such paper, in which mothers are involved in developing the messages, now covers more than 1 000 villages and is being expanded. The importance of strong women's organizations was also stressed.

In discussion a question was raised concerning the compatibility between the primary health care strategy that people in communities should determine their own health priorities, on the one hand, and the CSDR approach of identifying four specific initiatives for all communities to attack, on the other. It was pointed out that these four initiatives were recommended but not imposed and that they were not intended to be the exclusive content of educational programmes. The view was expressed that CSDR represents a point of entry for the development and implementation of primary health care. In addition it provides an excellent model and basis for intersectoral cooperation.

## 4. GOALS, STRATEGIES AND GUIDELINES

The International Consultation on Health Education for School-age Children did not formally adopt a final product. Rather, through development of reports in working groups, consideration and consolidation of those reports, it arrived by general consensus at an overall goal for health education of the school-age child, a set of very broad strategies for addressing this goal, and a number of suggested guidelines and approaches for carrying them out.

Since health learning actually takes place in the home, the school and the community where children live, these strategies and guidelines must ultimately be proved at the local level. But given the almost infinite diversity of the communities and the fact that most of the action needs to be initiated at national level, the country is the unit to which most of the suggestions are addressed, and most of them are couched in national terms.

Moreover, because nations themselves are so diverse, the approaches are necessarily somewhat generalized. No blueprint or "cookbook" is feasible. The strategies and guidelines outlined in this chapter constitute a set of issues that need to be resolved at country level and a series of proposed actions which each country should consider and adapt to its specific needs and circumstances.

Also included are suggestions for further action by the international agencies concerned.

4.1 The goal

In the context of social justice and as an important means of achieving health for all through the primary health care strategy, the health learning of the school-age child should be enhanced in every possible way so as to promote the exercise of self-reliance and social responsibility and a better quality of life for today's children and tomorrow's adults.

The following were considered as central ingredients for achieving this goal:

- value systems rooted in social justice and committed to health for all;
- the need to translate those values into normative behaviour;
- the child's overall development and optimal quality of life as the primary concern;
- the need to foster in young people a recognition that health is an essential life asset and an attitude that they themselves can affect their own health and that of their family and community;
- and the need to work through every possible channel to equip them not only with these values but with the knowledge and skills that empower them to act self-reliantly for their own health and that of their families and communities.

4.2 Strategies

(A) Define and develop health education for school-age children in ways which recognize and seek to integrate all the different avenues through which children learn about health.

In the past it has been customary to equate "health education of school-age children" with "school health education". Beyond question, the improvement of health instruction in the world's school systems is of vital importance and constitutes a massive challenge for educators and health workers.

But many millions of school-age children never get to school. Many millions more are there so briefly that they are scarcely benefited. Moreover, even for those in school attendance who receive instruction related to their health, the school is only one of many sources of health learning.

Broadening the definition of health education, and acting upon it, will require a re-examination of professional value systems and behaviour. It will also require a research strategy to explore such areas as how and where children learn about health, what sources can be deployed more effectively for health purposes, and what opportunities young people have to act on their knowledge and understanding. And it will require a strategy of experimentation, documentation and dissemination of approaches found successful.

(B) Develop functional collaboration among the national institutions and resources that affect or might affect children's learning about health.

First, and most obvious, effective cooperation and coordinated effort is needed between Ministries of Health and Education at national level and their regional and local counterparts. Unless a sense of shared responsibility for the health learning of children permeates both systems, educational efforts in health will continue to be fragmented, contradictory and ineffectual.

However, this partnership is only the beginning. Also needed are working relationships with mass media; with related sectors such as agriculture and commerce; with private enterprise; and with such nongovernmental organizations as women's groups and youth-serving agencies.

Specific patterns of organization and apportionment of responsibilities will obviously vary widely from country to country. Some suggestions for consideration appear in the guidelines.

(C) Develop a political will to deal effectively with the health learning of school-age children.

The urgently-needed collaboration among sectors and interests will never occur, and adequate resources will never be forthcoming, unless policy makers at the highest levels are convinced of the importance of this goal within their hierarchy of priorities. This

conviction must be active rather than passive. And it must continuously be renewed, for nothing is more dead than the priorities of yester-year.

A cornerstone of this strategy is the development of public awareness and enthusiasm. Rarely is such a political will initiated, and even more rarely is it sustained, unless the policy makers sense public interest and concern. In most societies at least two valuable resources exist for generating this enthusiasm: the mass media and the organized constituencies concerned with the well-being of children. Both need to be courted, cultivated and interlinked for the achievement of a common goal.

4.3 Guidelines

(A) Situation Analysis

Situation analyses at country, district and school level are useful steps in the development of an effective programme of health education. Such analyses will involve:

(i) the identification of major health problems and needs of the community including those of school-age children, by collecting not only demographic but also descriptive profiles of the health behaviour of children;

(ii) the assessment of existing health education programmes and other channels of health learning, their impact on the problems and needs identified and the extent to which they can be strengthened;

(iii) an assessment of the degree of intersectoral cooperation existing or achievable;

(iv) an assessment of resources actually or potentially available, and setting of priorities for the use of these resources;

(v) the selection of solutions and methodologies to be adopted for implementation.

The Consultation specifically recommended that all countries undertake situation analyses by the year 1990 at national level, drawing on analyses at community level.

(B) Research, documentation and evaluation

The research agenda for strengthening health learning of school-age children is extensive and diverse. There is also an urgent need for more effective mechanisms for disseminating the results of research already completed and in progress, so that countries can learn from each other. Among the many areas in need of such research and sharing of results are:

(i) collection and analysis of demographic data, especially related to non-school-going children, to identify who and where they are and through which pathways they may be reached;

(ii) behavioural research related to such questions as the health beliefs, values and interests of children; the motivation of teachers, health workers and administrators; the impact on children of conflicting values and behaviour; the relative effectiveness of different educational methodologies and approaches in bringing about desired changes; the accessibility and credibility of various channels of communication for children in different settings and cultures, and many more;

(iii) creative experimentation with new methodologies, or adaptation of existing ones to different settings, accompanied by objective documentation and evaluation of outcome;

(iv) communication research to assess such areas as the impact of commercial advertising on health attitudes and behaviour of children, the relative effectiveness of various media and modes of presentation, singly and in coordination, etc.

(C) Patterns of intersectoral collaboration

Each country starts from a different base and has its own particular circumstances with respect to organizational structures and allocation of responsibilities. The following guidelines are therefore proposed for consideration and country-specific adaptation:

(i) In most circumstances it appears desirable that the education sector have primary responsibility for health instruction in schools, and the health sector for school health services. This guideline alone demonstrates the absolute necessity for cooperation between the two sectors, from the highest Ministerial level down to the smallest community.

(ii) To help achieve this cooperation it is desirable to create a formal mechanism at inter-ministerial level, in the form of a permanent committee or task force, with sufficient authority to influence policies and practices throughout both systems.

(iii) With regard to the health learning of out-of-school children, the health sector will have the major responsibility in most circumstances and should actually collaborate with adult and non-formal education, mass media and voluntary organizations to reach these.

(iv) To deal with the broader issues of health learning, it is desirable to create a mechanism at national level which includes, at a minimum, representation of the governmental sectors of education, health and communication plus voluntary and other nongovernmental organizations, the principal mass media, and other concerned groups. Its function is to share information, influence policies and develop joint action.

(D) Integration of health education in school curricula

Countries, and often communities within countries, differ widely in the extent to which health instruction is presented to children in school and the manner in which it is provided. Following are some general guidelines:

(i) Health education should be pervasive to the whole educational environment, including:

(a) the teaching programme;
(b) the physical, mental and social environment of the school;
(c) the school health services;
(d) involvement of schools in services and activities to improve the total health status of the community.

(ii) The nature and quality of school health education programmes should be evaluated by the extent to which they achieve:

(a) instruction intended to motivate health maintenance and promote wellness and not merely the prevention of disease or disability;

(b) activities designed to develop decision-making competencies related to health and health behaviour;

(c) a planned, sequential pre-K end-of-school curriculum based on students' needs and current and emerging health concepts and societal issues;

(d) opportunities for all students to develop and apply in real-life situations health-related knowledge, attitudes and practices individually.

(iii) Health education should be taught as a specific subject at appropriate grade levels, and should also be consciously and actively incorporated in the teaching of other subjects.

(iv) Among the illustrative topics recommended for inclusion in health instruction are:

(a) special health problems and needs in the community;
(b) mental/emotional health;
(c) environmental health;
(d) family life and reproductive health;
(e) growth and development;
(f) nutritional health;
(g) personal health;
(h) prevention and control of disease and disorders;
(i) safety and accident prevention;
(j) drug abuse;
(k) exercise and physical education related to health.

(E) Human resources for health education

(i) It is important that all teachers and also educators of teachers receive some education related to health as a part of their basic professional preparation and that teachers currently in service receive training which will enable them to deal with health subjects competently and confidently.

(ii) Orientation and skill development in education and communication, especially two-way communication, should be incorporated in the professional preparation of physicians, nurses and all other health workers.

(iii) Interdisciplinary workshops and seminars involving health and mass media personnel can make a significant contribution to their mutual understanding and cooperation.

(iv) All programmes designed to prepare individuals for participation in health education activities of any kind should emphasize motivation as well as content.

(F) Development of materials

(i) There is a continuing need for improved and updated curricula and teaching materials which countries can adapt to their special circumstances and needs, both for health and family life education courses and for modules to be incorporated in other subjects.

(ii) Materials and modules designed to be used by a variety of non-school groups for the children not attending school are urgently needed. Such projects as CHILD-to-child, PACT and UNICEF's Child Survival and Development Programme are providing pioneering leadership in this area.

(iii) Inter-country exchange of successful curricula and materials, and some form of clearing house, would serve a highly useful purpose.

4.4 Suggestions to international agencies

The Consultation also suggested to WHO, UNICEF and UNESCO to examine the ways in which they could best help Member Countries in their efforts to strengthen the health education of the school-age child, in particular through: advocacy at the policy-making level, information sharing system, support for research, the publication of manuals for teachers and health workers, etc.

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